9

11

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

DONOVAN J. ANDERSON, M.D.

License No. 13491
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-08-0900A

CONSENT AGREEMENT FOR LETTER OF REPRIMAND

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Donovan J. Anderson, M.D. ("Respondent"), the parties agree to the following disposition of this matter.

- Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement").
 Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.
- 2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.
- This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.
- 4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.
- This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any

 waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

- 6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.
- 7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.
- 8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.
- 9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.
- 10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

HULUEN & ARMITH: To the state

| Way. |4. | 2009 | 11:53AW

760 326 7167

MEDICAL RECORDS 1

FINDINGS OF FACT

- 1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- Respondent is the holder of license number 13491 for the practice of allopathic medicine in the State of Arizona.
- 3. The Board initiated case number MD-08-0900A after receiving a complaint regarding Respondent's care and treatment of a forty-six year-old male patient ("DC").
- 4. On July 9, 2007, DC presented to the emergency department (ED) where he was seen by Respondent for complaints of left chest and elbow pain. DC's medical history was significant for coronary artery disease with myocardial infarction (MI) and coronary stent placement five years prior. Respondent ordered an electrocardiogram, a chest x-ray and labs that were interpreted as normal. Respondent discharged DC with a diagnosis of chest wall pain; however, there was no documentation to support this diagnosis as Respondent did not perform an accurate history and physical examination. Specifically, Respondent did not document DC's quality, duration or reproducibility of pain; whether the pain was constant or intermittent; or whether the pain was similar to that of his prior MI. There also was no documentation of DC's past medical history of prior MI, stent placement or elevated cholesterol.
- 5. Approximately five hours later, DC returned to the ED with worsening chest pain and was admitted to the hospital. A subsequent cardiac catheter showed 95% stenosis of the right coronary artery just past the original stent.
- 6. The standard of care requires an examining physician to perform an accurate history and physical examination during the evaluation and medical screening examination process that included quality, duration or reproducibility of the patient's pain; whether the pain was constant or intermittent; or whether the pain was similar to that of prior MI.

- 7. Respondent deviated from the standard of care because he did not perform an accurate history and physical examination during DC's initial ED visit.
- 8. Having been discharged with what appeared to be acute coronary syndrome, DC could have possibly progressed to transmural MI, profound disability, cardiac arrest, or death.
- 9. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there was no documentation to support a diagnosis of chest wall pain as Respondent did not document DC's quality, duration or reproducibility of pain; whether the pain was constant or intermittent; or whether the pain was similar to that of his prior MI.
- 10. Respondent has completed 15 20 hours of Category I Continuing Medical Education (CME) in diagnosing heart problems. In addition, Respondent provided Board Staff with satisfactory proof of completion on or before June 3, 2009.

CONCLUSIONS OF LAW

- The Board possesses jurisdiction over the subject matter hereof and over Respondent.
- 2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

7	ORDER
2	IT IS HEREBY ORDERED THAT:
3	Respondent is issued a Letter of Reprimand.
4	2. This Order is the final disposition of case number MD-08-0900A.
5	DATED AND EFFECTIVE this 4th day of June , 2009
6	APIZONA MEDICAL POARD
7	(SEAL) ARIZONA MEDICAL BOARD
8	
9	By Mule Dight Lisa S. Wynn
10	ORIGINAL of the foregoing filed
11	this 4th day of June, 2009 with:
12	Arizona Medical Board 9545 E. Doubletree Ranch Road Scottsdale, AZ 85258
13	
14	EXECUTED COPY of the foregoing mailed this 4th day of June, 2009 to:
15	
16	Scott Holden Holden & Armer, P.C. 6101 S. Rural Road, Suite 118 Tempe, Arizona 85283-2910
17	
18	
19	this 4th day of June, 2009 to:
20	Donovan J. Anderson, M.D. Address of Record
21	
22	Lowed Color
23	Investigational Review
24	
25	